

PLACE OF DEATH

County WarrenTownship Camp Branch

or

Village

or

City

(NO.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No.

Registered No.

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]FULL NAME Imajean Verginda Reisch

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

WhiteSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Singles

DATE OF BIRTH

Feb.
(Month)15th
(Day)1922
(Year)

AGE

10 yrs. 23 mos. 23 ds.If LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION

(a) Trade, profession, or
particular kind of work2001(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)Warren CO. MO.

PARENTS

NAME OF
FATHERHenry ReischBIRTHPLACE
OF FATHER

(City or town, State or foreign country)

Warren CO. MO.MAIDEN NAME
OF MOTHERBelle WatkinsBIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

Montgomery CO. MO.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hy. Reisch(ADDRESS) New Truxton, MO. R.F.D.

Filed

Jan 18 1922
W. H. Gehring
by H. A. Vahle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Jan.8th1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

191

to

191

that I last saw him alive on

191and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Viewed body in capacity of
Justice of Peace and certified
Coroner's Record that was
due to natural cause
the deceased being in the
Montgomery Hospital for the
deceased
(Duration) 1 yrs. 1 mos. 1 ds.Signed H. R. Jones, Jr.
Jan 9 1922
(Address) New Truxton
MO.*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)At place of death, 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.Where was disease contracted
if not at place of death?Former or
usual residence.

PLACE OF BURIAL OR REMOVAL

Pin Oak Cemetery

DATE OF BURIAL

Jan. 10th, 1922

UNDERTAKER

A. J. River.

ADDRESS

Truxton. MO.

PLACE OF DEATH

County _____

Township _____

or
Village _____

or
City _____

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

(NO. _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF BIRTH	
			(Month) _____ (Day) _____ (Year) _____	
AGE	yrs. _____ mos. _____ ds. _____		If LESS than 1 day, _____ hrs. _____ min. ?	
	yrs. _____ mos. _____ ds. _____		or _____ min. ?	

OCCUPATION
(a) Trade, Profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

NAME OF FATHER
BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER
BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191_____ REGISTRAR

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ (Address) _____ M. D. _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191_____

UNDERTAKER _____ ADDRESS _____

B.--Every item of information furnished by you so that it may be readily classified as "Very Important." Exact statement of occupation is very important.

REG. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

88!

617.5

..St. Ward)

ds.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*, *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificate, will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

2552